STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155358	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR CONVALESCENT & REHAB CENTER	3300 POPLAR ST TERRE HAUTE, IN47803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: 5/16-5/20/11 Facility number: 000249 Provider number: 155358 AIM number: 100267640 Survey team: Teresa Buske RN-TC Mary Weyls RN Laura Brashear RN Census bed type: SNF/NF: 68 Total: 68 Census payor type: Medicare: 6 Medicaid: 53 Other: 9 Total: 68 Sample: 15 Supplemental sample: 1 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 5/26/11 by Suzanne	F0000	Please accept this HCFA Plan of Credible Allegation of compliance.Meadows Manor has always and will continue to comply with all State and Federal Regulations. This survey does not reflect the actual care given to all residents of the facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Williams, RN			
F0164 SS=D	The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation and record review, the facility failed to provide personal privacy during incontinence care for 1 of 4 residents observed in a sample of 15, in that the room door was not	F0164	All residents of Meadows Manor East are to be given privacy when receiving care. This tag occurred because C.N.A. #1 did not follow the policy. To ensure resident #8 and all other residents are not affected again, an inservice was held on May 26, 2011, for all CNAs (see attached #1). Also the Inservice Director will do periodic checks on CNAs when	05/26/2011

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	completely closed or the privacy curtain pulled around the resident's bed. [Resident #8] Finding includes: On 5/17/11 at 10:55 a.m., CNA #1 was observed to provide incontinence care to Resident #8 while the resident was in his bed. The incontinence brief was removed, and the resident was exposed during cleansing of the skin. The door to the resident's room was not completely closed, and the privacy curtain was not pulled around the resident's bed. During the care, another staff member partially entered the resident's room. A facility policy titled "Incontinence Care," [no date]		doing resident care. Any CNA not following policy will receive 1 on 1 inservice at this time. Repeated infractions will result in written warning or termination. Any violations will be brought to Q.A. Meetings.Monitored by: Inservice Director, D.O.N., Administrator, and Q.A. Committee.	

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	provided by the DON on 5/20/11 at 9:40 a.m., included, but was not limited to, "Screen and drape resident for maximum privacy." 3.1-3(p)(4)			
F0246 SS=D	A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.			
	Based on observation and record review, the facility failed to provide a bed that accommodated a resident's length for 1 of 13 residents in a sample of 15, observed while in bed, with their feet resting on top of the footboard. (resident #8) Findings include: On 5/17/11 at 10:55 a.m., CNA (certified nurses' assistant) #1 was providing care to resident #8. The resident was in bed during care and was observed with his feet resting on top of the footboard. On 5/17/11 at 2 p.m., resident #8 was in bed, with his feet resting on the footboard. On 5/20/11 at 5:45 p.m., the resident was in bed. The resident's feet were up against	F0246	Meadows Manor East ensures all residents receive reasonable accommodations to fulfull their needs and preferences. All the beds are standard size and meet regulations for size. Resident #8 is a 6 foot tall man. He receives bolus feedings, so the head of his bed is at a 30 degree angle. He also scoots himself down in his bed. This makes his feet touch the footboard. To ensure resident #8 does not touch the footboard, a larger size bed and mattress has been placed in resident #8's room. The increase in size is 78" to 84". All other residents presently on tube feedings will be monitored for bed size, as well as any future residents. Anyone needing a bigger size bed will be given one. Monitored by: D.O.N., A.D.O.N., and Q.A. Committee	06/03/2011

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	the foot board. Review of the clinical record of Resident #8 on 5/16/11 at 1:30 p.m. indicated the resident was 6 feet tall in height. 3.1-3(v)(1)			
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation and record review, the facility failed to thoroughly cleanse a resident's skin after an incontinence episode, for 1 of 4 residents observed during care in a sample of 15. (Resident #8) Finding includes: On 5/17/11 at 10:55 a.m., Resident #8 was observed in bed with an incontinence brief on. CNA #1 was observed to remove the brief and to cleanse	F0312	All residents receive proper incontinence care. Resident #8 does receive good incontinence care. His skin is in good condition, and he has no open areas. He is on a bolus feed, and does not like to be out of bed. All of which can cause skin break down. These things prove he usually does get incontinence care. This tag occurred because CNA #1 did not follow proper procedure given to all residents. To prevent Resident #8, all current residents, and any future residents from having a reoccurrence, an inservice was held on June 3, 2011 (see attached #'s 1 & 2). The inservice director will do periodic checks on CNAs when they are doing incontinence care. Any irregularities will receive a 1 on 1 inservice at the time of occurrence. Repeated infractions will result in written warnings or terminations. All infractions will	06/03/2011

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	the resident's perinea area. The resident was then positioned on the side, and the CNA placed a clean brief underneath the resident. The CNA indicated the resident's brief had been saturated with urine. The resident's buttocks, which had been in contact with the soiled brief, was not cleansed. The resident was turned onto the back and brief fastened. The facility's policy titled "Incontinence Care" [no date] provided by the DON on 5/20/11 at 9:40 a.m. included, but was not limited to, "PURPOSE: 1. To keep skin clean, dry, free of irritation and odor. ...GENERAL INFECTION CONTROL GUIDELINES 4. Clean and dry skin well before and after procedure."		be reported to the Q.A. Committee.Monitored by: Inservice Director, Administrator, D.O.N., and Q.A. Committee	

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F0323 SS=D	3.1-38(a)(3)(A) The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review and interview, the facility failed to ensure 1 of 5 residents (#28) identified as requiring interventions to provide safety, and 1 of 2 residents (# 6) observed utilizing mechanical lifts in a sample of 15, received adequate supervision to prevent accidents, in that interventions to provide safety were not implemented and manufacturer's recommendations were not followed when utilizing mechanical lifts. Findings include: 1. During initial tour on 5/16/11 which began at 11:35 a.m., LPN #10 indicated resident #28 rolls out of bed, but was unaware of the resident having any recent falls out of bed. On 5/17/11 at 2 p.m., resident #28 was observed in bed. An alarm cord was extended out from under the covers, but was not attached to an alarm box. The bed was observed up against the wall. A	F0323	1. Resident #28 is to have an alarm and pillow in place at all times, and normally, these two interventions are in place. This occurred due to not following the care plan. To prevent this tag from happening again, these interventions for this resident and all other residents will be placed on the CNA's assignment sheets. Also, an inservice was held on June 3, 2011, for all CNAs and nurses (see attached #1). The D.O.N., A.D.O.N., and inservice director will do daily checks to ensure pillow and fall alarm is in proper place. Evening and night supervisors will monitor their shifts. Information on checks will be reproted to Fall Committee and Q.A. Committee.Monitored by: D.O.N., A.D.O.N., Fall Committee and Q.A. Committee2. Resident #6 is lifted by the Arjo lift. CNAs #4 & #9 did not follow proper protocol when transferring this resident. To prevent a reoccurrence of this tag, an inservice was held on May 26, 2011, on the proper use of mechanical lifts (see attached #1 & #3). The inservice director will watch at least one random	06/03/2011

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	pillow was not observed between the resident and the outer edge of the bed. On 5/18/11 at 10:40 a.m., resident #28 was observed in bed on the left side. A pillow was not observed between the resident and the outer side of the bed. On 5/19/11 at 9:55 a.m., resident #28 was observed in bed. A pillow was not observed between the resident and the outer side of the bed. Resident #28's clinical record was reviewed on 5/19/11 at 10:10 a.m. A plan of care (POC) was noted, dated 4/19/11, indicating "At risk for falls/injury related to history of falls/has Parkinson disease/osteoporosis." An intervention was noted of, but not limited to, pressure alarm to bed and wheelchair to alert staff of unsupervised transfers. The POC also identified "At risk for falls/injuries to falls," dated 5/8/11, which identified an approach of "Bed against wall with bolster pillow on side." During interview of the DON (Director of Nursing) on 5/18/11 at 2:05 p.m., the DON indicated resident #28 had incidents of rolling out of bed on 3/25/11, 4/3/11, and 5/8/11.		transfer a week and will report any errors to the D.O.N. or A.D.O.N. who will bring these to the morning meeting daily, and the monthly Q.A. Meeting. Repeated errors by staff will result in a written reprimand.Monitored by: Inservice Director, D.O.N., A.D.O.N., and Q.A. Committee	

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	2. On 5/19/11 at 9:30 a.m., Resident #6 was observed to be transferred from the wheelchair to bed with the Arjo mechanical lift by CNAs #4 and #9. The base of the lift was opened around the wheelchair and rear castors locked. The resident was raised with the lift, with the 'jib' at the highest part of the red indicator located on the mast. The resident was positioned parallel to the mast during the transfer. The legs of the lift were kept in the open position during the transfer, and was pushed over a spongy floor mat next to the resident's bed. Resident #6's clinical record was reviewed on 5/17/11 at 10:15 a.m. A form titled "Lift	F0323	1. Resident #28 is to have an alarm and pillow in place at all times, and normally, these two interventions are in place. This occurred due to not following the care plan. To prevent this tag from happening again, these interventions for this resident and all other residents will be placed on the CNA's assignment sheets. Also, an inservice was held on June 3, 2011, for all CNAs and nurses (see attached #1). The D.O.N., A.D.O.N., and inservice director will do daily checks to ensure pillow and fall alarm is in proper place. Evening and night supervisors will monitor their shifts. Information on checks will be reproted to Fall Committee and Q.A. Committee.Monitored by: D.O.N., A.D.O.N., Fall Committee and Q.A. Committee2. Resident #6 is lifted by the Arjo lift. CNAs #4 & #9 did not follow proper protocol when transferring this resident. To prevent a reoccurrence of this tag, an inservice was held on May 26, 2011, on the proper use of mechanical lifts (see attached #1 & #3). The inservice director will watch at least one random transfer a week and will report any errors to the D.O.N. or A.D.O.N. who will bring these to the morning meeting daily, and the monthly Q.A. Meeting. Repeated errors by staff will result in a written reprimand.Monitored by: Inservice Director, D.O.N.,	06/03/2011

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	Assessment Form," dated 4/5/11, included "Lift to use: Arjo/Maxi, ...When using the lifts remember the following: Legs MUST be PARALLEL to transport the resident. (Even just a few feet) Lift height MUST be in GREEN area to transport resident. (Even just a few feet) Comments: Resident refuses to bear weight to assist in transfers." Manufacturer's directions provided by the DON on 5/20/11 at 9:30 a.m. included, but was not limited to, "CAUTION! Transport the lift with chassis legs in parallel position only." During transportation turn the patient so that they face backwards at normal chair height-this gives confidence ... ALWAYS MAKE SURE THAT: 5.		A.D.O.N., and Q.A. Committee	

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	patient transport only takes place when the chassis legs are parallel and the lift is at its correct transportation height and that the height indicator is within the green area during transport." 3.1-45(a)(2)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview the facility failed to sanitize dishes and utensils in that the dishmachine failed to register sanitizing solution. This had the potential to affect 66 of 68 residents who received meals from the kitchen. Findings include: During kitchen observation on 5/16/11 at 11:25 p.m., with the Food Service Supervisor (FSS), the test strips failed to registered chemical sanitation in the dishmachine. The FSS attempted three times, and the testing strips indicated zero	F0371	This Ftag is not the norm for this facility. Sanitary conditions are to be and are followed. There was a problem with the dish machine the week before, and Ecolab was called in to service it. The temperature and chemical were correct at this time (see attached #4). This tag occurred because dietary staff did not follow procedure. Upon day of survey, it was noticed that the chemical was not advancing up the tube. Ecolab was called in immediately, and they had to replace a worn sanitizer tube (see attached #5). To ensure proper procedure is followed, an inservice was held on May 16, 2011 (see attached #6) for dietary staff, and a new	06/03/2011

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	chemical. The tubing extending from the sanitation bucket to the dishwasher was observed not to advance up the tubing, to the dishwasher during the sanitation cycle. During interview of the FSS on 5/16/11 at 11:35 a.m., the FSS indicated the chemical is from "Echolab." The FSS indicated the sanitizer was bleach and should register at 50 parts per million (ppm) and the water temperature should be at least 120 degrees Fahrenheit (F). The FSS indicated a representative from Echolab was just out last week. Review of the "Dish Machine Temperature Log", received on 5/16/11 at 11:45 a.m., from the FSS, indicated May 1, 2, 3, and 5, 2011 did not have documentation of the rinse water temperature or what the chemical strip registered. Documentation of rinse temperatures for May 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 2011, indicated the temperatures for breakfast, lunch and supper varied between 108 F to 119 F. A column dedicated to document the chemical results documented the water temperature instead. Review of the facility "Dishwashing Policy" dated 3/97, and received from the FSS on 5/16/11 at 1:10 p.m., documentation indicated "Check for		sheet has been put in place for chemical test strips (see attached #7) to be placed, as well as using a sheet for temps and PPM. These implementations will ensure that all current and future residents will not have this deficiency occur again. Any discrepencies will be brought to the morning meeting, and monthly Q.A. Meeting. Monitored by: Dietary Manager, Administrator, and Q.A. Committee	

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	adequate level of detergent, rinse, and sanitizer before each meal. Checks will be made before breakfast, lunch, and dinner dishes are washed." and "If temperature below 120 [degrees] or chlorine test strip below 50 parts per million, NOTIFY SUPERVISOR IMMEDIATELY." The documentation also indicated the "Dietary Supervisor will be responsible for making sure breakfast and lunch check completed and documented properly. Head Cook will be in charge of dinner documentation and for all meals on weekends, in Dietary Supervisor's absence." During interview of the FSS on 5/16/11 at 2:45 p.m., the FSS indicated she was unaware of the low temperatures that were being documented for the dishmachine. 3.1-21(i)(3)			

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F0441 SS=D	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation and record review, the facility failed to ensure hand hygiene	F0441	Meadows Manor East has and follows an Infection Control Program, which is to be followed at all times. 1. CNAs #4 & #9, should have had gloves on when touching the catheter tubing on	06/03/2011

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	155358	A. BUILDING 00 B. WING	05/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR CONVALESCENT & REHAB CENTER	3300 POPLAR ST TERRE HAUTE, IN47803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for 1 of 1 observation of Foley catheter handling, 1 of 4 observations of incontinence care in a sample of 15 and 1 of 1 observation of a nebulizer treatment in a supplemental sample of 1. [Residents #12, #6, and #20] [CNAs #11, #4, #9] [LPN #10] Findings include: 1. On 5/19/11 at 9:30 a.m., CNAs #4 and #9 were observed to transfer Resident #6 from the wheelchair to bed, with a mechanical Arjo lift. The resident was observed to have an indwelling, Foley catheter. The CNAs were observed holding the catheter tubing during the transfer without wearing gloves, and after positioning the resident in bed, handled the resident's		resident #6. To prevent further occurrence, an inservice was held on June 3, 2011 (see attached #8 and #9). 2. LPN #8 did not follow protocol when giving resident #20 a nebulizer treatment. To ensure this resident and all residents receive proper procedure, an inservice was held for all nursing personnel on June 2, 2011 (see attached #9).3. CNA #11 did not follow proper procedure when giving care to resident #3. An inservice was held for all CNAs on June 3, 2011 on the procedure for use and removal of gloves and handwashing (see attached #'s 8 & 9). This will ensure that this resident and all residents will receive proper care when changing a brief. This Inservice Director, D.O.N., and A.D.O.N. will do periodic checks on nursing staff to monitor all three of these deficiencies. Anyone doing improper procedures will receive 1 on 1 instruction. Any discrepencies will be reported in morning meetings and monthly Q.A. Meetings. This will ensure that these three residents, any other current residents and any future residents will not have this Ftag occur again.Monitored by: Infection Control Nurse, D.O.N., A.D.O.N., and Q.A. Committee	

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	wheelchairs, and privacy curtains before washing hands. 2. On 5/18/11 at 11:45 a.m., LPN #10 was observed to provide a respiratory nebulizer treatment to Resident #20. Without wearing gloves, the LPN entered the resident's room, picked up the nebulizer treatment from the resident's bedside table, poured two medications into the nebulizer mask and handed it to the resident. The LPN exited the room and used hand gel at the medication cart. 3. On 5/19/11 at 11:30 a.m., CNA #'s 11 and 12, provided care to resident #12. CNA #11 washed the resident's rectal area and buttocks, and while wearing the same gloves, placed a clean incontinence brief and pulled the resident's slacks up. A facility policy titled "Handwashing" and dated 2007 was received from the DON on 5/20/11 at 9:40 a.m.			

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	The policy indicated handwashing should be performed after touching organic material, and after handling contaminated equipment. 3.1-18(l)			